DEPARTMENT	OF HEALTH AND HUMAN	SERVICES
CENTERS FOR	MEDICARE & MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155779		LDING	01	08/08/2011	
		100770	B. WIN		ADDRESS CITY STATE TIN CODE	00/00/2011	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RAIRIE LAKES BOULEVARD E	Δ.	
PRAIRIE LAKES HEALTH CAMPUS			NOBLESVILLE, IN46060				
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		EFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
K0000							
	_ <del>-</del>	de Recertification and Survey was conducted by	K	0000	Prairie Lakes Health Campus submits this plan of correctio		
		Department of Health in			response to the allegations of		
		•			noncompliance cited during t	he	
		42 CFR 483.70(a).			Life Safety Code Survey conducted on August 8, 2011.Please accept this plan	of	
	Survey Date: 08/	/08/11			correction as the providers le of credible allegation of		
	Facility Number:	012305			compliance effective Septem	ber	
	Provider Number: 155779 AIM Number: 200987990 Surveyor: Mark Caraher, Life Safety				5, 2011		
	Code Specialist	,					
		ry Code survey, Prairie					
		mpus was found not in					
	compliance with	Requirements for					
	Participation in N	Medicare/Medicaid, 42					
	CFR Subpart 483	3.70(a), Life Safety from					
	Fire and the 2000	Edition of the National					
	Fire Protection A	ssociation (NFPA) 101,					
	Life Safety Code	(LSC), Chapter 18, New					
	Health Care Occu	upancies and 410 IAC					
	16.2.						
	_	sists of two separate one					
		onsisting of the Main					
		and the Legacy building.					
	Each building is	• • • • • • • • • • • • • • • • • • • •					
		fully sprinklered and has					
		m with smoke detection					
	in the corridors, r	resident sleeping rooms					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J76W21

Facility ID:

012305

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
		IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLET 08/08/201					
		155779	B. WIN			08/08/2	011	
	NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  9730 PRAIRIE LAKES BOULEVARD EAN NOBLESVILLE, IN46060				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	_	o the corridor. The acity of 130 and had a						
	census of 63 at th	ne time of this survey.						
		Robert Booher, Life Safety dical Surveyor on 08/15/11.						
	l -	found not in compliance						
		ntioned regulatory						
	requirements as effollowing:	evidenced by the						
K0038 SS=F	8 Exit access is arranged so that exits are		K	0038	K 038It is the practice of thi provider to ensure that exit access is arranged so that exits are readily accessible all times; however in resport to the 2567 findings, the following measures and corrective actions have bee taken:  Corrective Actions accomplis for those residents found to heen affected by the alleged deficient practice:  The Legacy unit was designed a secured memory care unit with the exit doors remaining lock by an electromagnetic lockin device. The doors are wired the fire detection system to automatically release if the system was activated and to	at nse en shed ave d as with red	09/05/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J76W21 Facility ID:

D: 012305

If continuation sheet

Page 2 of 8

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:		DING	01	COMPLETED	
		155779	A. BUILDING B. WING			08/08/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	R			RAIRIE LAKES BOULEVARD E	Δ:	
PRAIRIE LAKES HEALTH CAMPUS					SVILLE, IN46060	Λ'	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	$\neg$	ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE	DATE
	Findings include	:			remain unlocked until the fire	e	
					protection signaling system i	s	
	Based on observ	ations with the			manually reset. During prev	ious	
		nd the Director of Plant			inspections and monthly fire		
					testing, the doors have worke		
	1 ^	g a tour of the facility			designed and released with the		
	_	o 3:45 p.m. on 08/08/11,			activation of the fire alarm.		
		etic locks on all nine			During this inspection the sy	stem	
	Legacy building	exit doors did not release			malfunctioned and the		
	and remain unlo	cked when the fire alarm			electromagnetic locks remain	ned	
	was activated at	3:24 p.m. Based on			engaged after the fire alarm v		
	interview at the t	time of the observations,			activated.		
	the Director of P		The provider's vendor was				
		ach of the nine Legacy			immediately contacted and		
	1	ors electromagnetic locks			informed of the malfunction	and	
	1	ased and remained			priority service was schedule	ed.	
			The vendor's analysis detected a faulty circuit board which did not				
		he fire alarm was					
	activated.				allow the electromagnetic lo		
					to release. The circuit board		
	3.1-19(b)				replaced and the system was		
					returned to proper functionin	g	
	2. Based on obse	ervation and interview,			status.		
		to ensure 1 of 9 Main					
	1	g exits was readily					
	accessible at all times in accordance with						
		. LSC Section 7.1			Identification of other residen	nts	
					having the potential to be		
	requires means of egress for existing buildings shall comply with Chapter 7.  LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. This deficient				affected by the same alleged		
					deficient practice and the		
					corrective actions implement	ed:	
					All Residents residing on the		
	practice could af	fect any resident, staff or			Legacy Unit have the potenti	al to	
	visitor needing to	o exit the Main Campus			be affected by the alleged		
	1	e Pioneer Hall exit.			deficient practice.		
	<i>3</i> 1 2 2 2 2 4 1 1						
	L				<u>!</u>		

		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	01	COMPLETED	
		155779	B. WIN			08/08/2011	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RAIRIE LAKES BOULEVARD E	Λ'	
DDVIDIC	LAKES HEALTH CA	AMPLIS		1	RAIRIE LAKES BOULEVARD E SVILLE, IN46060	<u>~</u>	
PRAIRIE	LAKES HEALTH CA	AMPUS		NOBLE	SVILLE, IN40000		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Findings include						
	Operations durin from 1:10 p.m. to the exit discharge Campus building	d the Director of Plant g a tour of the facility o 3:45 p.m. on 08/08/11, e outside the Main g Pioneer Hall exit was			Measures implemented and systemic changes made to en that the alleged deficient practices not recur:  The fire drill report sheet has been modified to include	etice	
	Based on interview observation, the Avisitors who have building entrance the Main Campus Pioneer Hall entrapark at the exit diacknowledged the public way was be	Administrator stated e been granted the e access code may enter s building from the rance and usually don't			inspection of the electomagn locks to ensure proper release with activation of alarm. Each time that the fire alarms are activated during a drill the electromagnetic locks will be inspected and results will be documented, any malfunction of the system will immediate be reported to the Executive Director and or the Director of Plant Operations	e ch ing dly	
	parked car. 3.1-19(b)				Plant Operations.  How the corrective action wi monitored to ensure the alleg deficient practice will not reconstruction. Director of Plant Operations Designee will conduct month fire drills and system inspect.  Results of the fire drills and system inspections will be reported to the Governing Quality Assurance committee.	ged cur: or ally ions.	
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: J	76W21	Facility I	D: 012305 If continuation sl	heet Page 4 of 8	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE SURVEY COMPLETED 08/08/2011		
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  9730 PRAIRIE LAKES BOULEVARD EA  NOBLESVILLE, IN46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
				monthly for one (1) quarter quarterly thereafter.	and		
				Corrective Actions accomple for those residents found to been affected by the alleged deficient practice:  During this inspection a visit had parked her car at the end the sidewalk long enough to in some supplies to their farmember, blocking the public way. The visitor was immediatedly asked to movear. A sign was added marked this area as a no parking zor Identification of other reside having the potential to be affected by the same alleged deficient practice and the corrective actions implement.  Any resident needing to exist Main Campus building usin Pioneer Hall exit has the potential to be affected by the alleged deficient practice.  Measures implemented and systemic changes made to exist many changes made to exist many contents.	tor d of run nily c re her ing ne. ents l tted: tthe g the ne		
				that the alleged deficient pra	actice		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MU A. BUIL B. WINC		01	(X3) DATE SURVEY COMPLETED 08/08/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  9730 PRAIRIE LAKES BOULEVARD EA: NOBLESVILLE, IN46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
					does not recur:  Staff will be inserviced and educated to inform them of the need for building exits to remaccessible and for the sidewa that lead to the public way to remain unblocked at all times.	nain lks	
					How the corrective action wi monitored to ensure the alleg deficient practice will not rec The ED or designee will observe the no parking sign remains in p and that the exits remain unbloc	ed ur: e that lace ked.	
					This audit will occur weekly for weeks, monthly for 5 months an quarterly thereafter to ensure compliance. Results of the audit be reported to the Quality Assur Committee for a minimum of 6 months then randomly thereafte	will ance	
K0144 SS=F		spected weekly and lad for 30 minutes per lice with NFPA 99.					
	Based on observation facility failed to a generators were a manual stop. NF Facilities, 3-4.1.1 installed as alternative and the state of the state	ention and interview, the ensure 2 of 2 emergency equipped with a remote PA 99, Health Care 1.4 requires generator sets nate power sources shall ments of NFPA 110,	K0	144	It is the practice of this provider to ensure that our Generators are inspected weekly and exercised under load for 30 minutes per mor however in response to the 2567 findings, the following measures and corrective	nth;	09/05/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J76W21 Facility ID:

012305

If continuation sheet

Page 6 of 8

li ´		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155779	B. WIN	۱G		08/08/2011
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
				1	RAIRIE LAKES BOULEVARD E	A:
PRAIRIE LAKES HEALTH CAMPUS				NOBLE	SVILLE, IN46060	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
		ergency Standby Power			actions have been taken: K 144	
	•	110, 3-5.5.6 requires			K 144	
		ions shall have a remote				
	-	on of a type similar to a			Corrective Actions accompli	shed
	_	on located elsewhere on			for those residents found to h	nave
	-	ere the prime mover is			been affected by the alleged	
		ne building. This			deficient practice:	
	deficient practice	e could affect all				
	occupants in the	Main Campus building			A remote manual shut off de	
	and in the Legac	y building.			was installed and tested by the	ne
					providers vendor.	
	Findings include	:				
					Identification of other reside	nts
	Based on observa	ations with the			having the potential to be	
	Administrator an	d the Director of Plant			affected by the same alleged	
	Operations durin	g a tour of the facility	deficient practice and the			
	from 1:10 p.m. to	o 3:45 p.m. on 08/08/11,			corrective actions implement	ted:
	_	remote shut off device				
	was found for the	e Main Campus building			All residents have the potent	ial to
		rator and for the Legacy			be affected by the alleged	
		ncy generator. The Main			deficient practice.	
		g emergency generator is				
		and the Legacy building			Measures implemented and	
		rator is rated at 80 kW.			systemic changes made to en	sure
		vas manufactured in			that the alleged deficient pra-	ctice
	_	Based on interview at			does not recur:	
	the time of observation, the Director of				The staff will be inserviced of	nn
		acknowledged each			the purpose, and protocal for	
	•	rator was not equipped			of the manual shut off device	l l
	with a remote sh				or the manage shat on device	<i>"</i>
	with a remote sin	at off device.				
	3.1-19(b)				How the corrective action wi	
	3.1-17(0)				monitored to ensure the alleg	
					deficient practice will not rec	cur:
					<u> </u>	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/08/2011		
NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  9730 PRAIRIE LAKES BOULEVARD EA: NOBLESVILLE, IN46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	The Director of Plant Opera will conduct monthly inspect of the emergency generator include inspection of the remanual shut off device.  Results of the system inspect will be reported to the Gove Quality Assurance committed monthly for one (1) quarter quarterly thereafter.	ations ections to mote ections erning ee		